RESERVE

MAGAZINE NOVEMBER/DECEMBER 1974

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American unit to reach Tokyo.

In Japan the men didn't wear the "Constabulary" patch on their shoulders as did US troops in Europe but the Division was reduced in size to perform in constabulary duties. The third battalion in each regiment was inactivated. At less than two-thirds strength for more than four years, the Division grew soft. The lack of men, equipment and hard training became obvious when the Division was committed to Korea in 1950.

The First Team was the first American unit to make a full-scale amphibious landing during the Korean War and the first to capture a Communist capital. But the Cav suffered badly in Korea, a lesson that the Army and every man who ever served there would not forget.

When the First Team furled its colors in Korea to become the 1st Cavalry Division (Airmobile), the men left behind still remembered the stories about the 8th Regiment, which in one bitter engagement lost over 1,000 of its 1,481 men. And they still talked about the Cavalrymen who had been found shot, their hands tied behind their backs with their own boot laces.

The battle streamers on the Division's flag don't tell the whole story nor do the Army's official lineages. The lineages only hint at how the regiments, troops and squadrons have been reshuffled dozens of times.

That's the way it goes, but that's not how the 11th Air Assault became the 1st Cav. When it was finally determined that skytroopers would be sent to Vietnam, Gen. Harold K. Johnson, then Chief of Staff, called General Howze and asked him if he thought it would be appropriate to name this new airmobile outfit the 1st Cavalry Division. General Howze thought it over and answered yes. And it was done. Mounted soldiers had something to do with it. But so did General Howze, the man responsible for developing the airmobile concept. His father had been the first commander of the original 1st Calvary Division.

The Doctor Shortage Hits

As of June 1974, the military was more than 1,800 doctors understrength, with the Navy suffering the most. According to the Surgeon General, by December 31, 1974, the Army's Medical Corps expects to have 458 fewer doctors than a year ago.

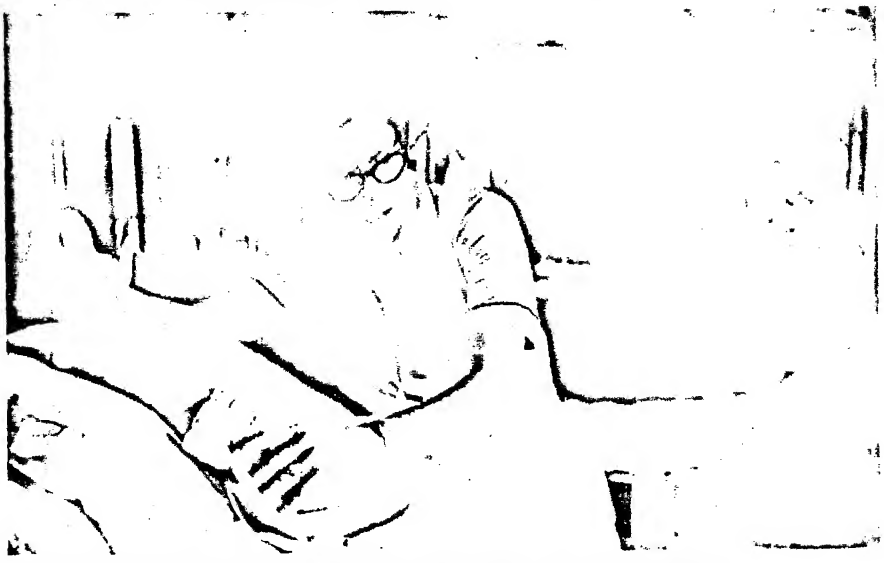
The doctor shortage was anticipated. It is the result of an overall strength reduction, the end of the doctor draft, and the services' inability to retain a sufficient number of doctors. The obvious fact remains that doctors can make more money on the outside. Even the recently enacted bonuses, available in amounts up to $13,500 annually for service physicians who agree to remain on active duty an additional one to four years, will not provide service doctors with pay equal to their civilian counterparts.

To remedy the situation, the Department of Defense has received approval from the Civil Service Commission to hire retired service doctors, who according to the law and under ordinary circumstances would forfeit one half of their retired pay in excess of $3,250 if they were reemployed by the Federal Government.

Under the exception to the law which has been granted, retired regular military physicians accepting civilian positions with the Department of Defense will be paid comparable to the median incomes of physicians who have been practicing medicine for 20 or more years in civilian communities.

In practical terms, that means if a retired Army colonel drawing full retirement pay ($19,707) is hired by the DoD as a civilian doctor at the starting salary for a GS-13, step 1, he receives in additional $20,677 a year for a total of $40,384.

Another solution to the doctor shortage is becoming available. Waiting in the wings are a large number of medical students who, under a bill passed by Congress, have received Government scholarships. Their medical school expenses will be paid by the Government in return for a prescribed period of active military service. However, it will be some time before graduates of this program are ready to begin their Army



RESERVE THERAPISTS HAVE WORKED OVERTIME DURING TRAINING

AN EXTENDER

RESERVISTS, LIKE THESE CAN HELP OUT DURING WEEKENDS . . .

BUT LINES CAN ONLY BE EXPECTED TO INCREASE

careers.

Throughout the Army, programs are underway to assign the best and the brightest medical personnel to special programs which are designed to provide patients with the services traditionally performed by "physicians but not necessarily requiring doctors." Sometimes known as "health care extenders," these medics have been classified as physicians assistants and nurse clinicians. Physicians assistants, graduates of a two-year course at Fort Sam Houston, are promoted to Warrant Officer on graduation. Nurse clinicians, usually with a masters-level education in a speciality like obstetrics, gynecology or intensive care, are authorized to provide care in their specialized fields. Soldiers in the AMOSIST (Automated, Military Out-patient Systems Training) program spend 12 weeks learning how to identify and refer, or provide care to, walk-in outpatients affected by acute minor illnesses who are not in what could be described as "emergency situations."

Particularly affected by the current doctor shortage are retired regular and Reserve servicemen and women and their dependents who in the past several months experienced changes in CHAMPUS (Civilian Health and Medical Program of the Uniformed Services). With medical care being curtailed at service hospitals worldwide, CHAMPUS looks like the answer, even though the retired serviceman has to foot 25 percent of the bill. However, during the past few months CHAMPUS benefits have been reduced.

Braces are out, except in extraordinary cases. Although in- and outpatient psychiatric care underwent a temporary change late this summer, care remains essentially the same pending review by the Department of Defense. Maternity care remains the same, although this benefit is of dubious value to retired Reservists.

The doctor shortage comes at a time when the total population entitled to Army medical care, despite reduced Army strength, is at an all-time high. And because of the widening gulf between the people entitled to care and medical assets, which are tied to active strength, some medical treatment facilities may now be as much as 40 percent below manning levels.

Reservists drawing retired pay are entitled to treatment at VA facilities. They and their dependents are also entitled to treatment under CHAMPUS and at active military hospitals *insofar as the hospitals can treat retirees without endangering their primary mission*. The doctor crunch is on.